Appendix I: Financial Accountability

APPENDIX I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Contract Audit Requirements

The following language from the FY 06 contracting template applies to contractors of DDP waiver funded services:

8.1 The Contractor, in accordance with 18-4-311, MCA and other authorities, must maintain for the purposes of this Contract an accounting system of procedures and practices that conforms to Generally Accepted Accounting Principles (GAAP), as interpreted by the Department, and to any other accounting requirements the Department may require.

8.2 The Department or any other legally authorized governmental entity or their authorized agents may at any time during or after the term of this Contract conduct, in accordance with 5-13-304, MCA and other authorities, audits for the purposes of assuring the appropriate administration and expenditure of the monies provided to the Contractor through this Contract and assuring the appropriate administration and delivery of services provided through this Contract.

8.3 The Contractor, for purposes of audit and other administrative activities, in accordance with 18-1-118, MCA and other authorities, must provide the Department and any other legally authorized governmental entity or their authorized agents access at any time to all the Contractor's records, materials and information, including any and all audit reports with supporting materials and work documents, pertinent to the services provided under this Contract until the expiration of six (6) years from the completion date of each respective state fiscal year.

8.4 The State and any other legally authorized governmental entity or their authorized agents may record any information and make copies of any materials necessary for the conduct of an audit or other necessary administrative activity.

8.5 A non-profit contractor, if receiving $500,000 or more in federal funds from any and all federal funding sources, must comply with the accounting and audit requirements of Federal Office of Management and Budget (OMB) Circular A-133, "Audits of States, Local Governments, and Non-Profit Organizations" and the provisions of OMB Circular "A-122, Cost Principles for Non-Profit Institutions" concerning the use of the funds provided under this Contract.

8.6 A for-profit contractor must comply with the accounting and audit requirements in 45 CFR 74.26(d) and the cost principles and procedures for commercial organizations in 48 Subpart CFR 31.2 concerning the use of the funds provided under this Contract in the version in effect on the date this Contract is signed by both parties. Pursuant to 45 CFR 74.26(d), a "for-profit" organization may either have an audit conducted in accordance with the Federal Office of Management and Budget (OMB) Circular A-133, "Audits of States, Local Governments, and Non-Profit Organizations" or the Government Auditing Standards.

For non-profit corporations receiving $500,000 or more in federal funds from any and all funding sources, or for-profit corporations, the contractor is responsible to have yearly audits conducted in accordance contract provisions (above). The DPHHS Quality Assurance Division conducts annual desk reviews of these audits to identify substantial risk in integrity and to establish the effectiveness of the corporations internal controls.

For non-profit corporations receiving less than $500,000 in federal funds from any and all federal funding sources, the Quality Assurance Division is responsible to conduct limited scope audits of agreed upon procedures.

Rates Project

The Quality Assurance Division is in the process of developing a Service Utilization Review (SURS) methodology based on input from project and DDP staff. This review process will replace the auditing procedures outlined above for all providers participating in the rates methodology project. The SURS process will help ensure the integrity of provider invoicing, based on assurances that contracted hours are being delivered.

APPENDIX I-2: Rates, Billing and Claims

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The DDP Regional Managers negotiate rates with providers through the annual contracting process. The rates generally continue from year to year by provider, with contract adjustments based on legislative appropriations for general provider rate increases and/or direct care staff salary enhancements. There is opportunity for input and testimony via various forums and public notices related to legislative activities. ARM 37.34.973 references the current State practice in regions not involved in the "rates pilot project".

37.34.913 MEDICAID HOME AND COMMUNITY SERVICES PROGRAM: REIMBURSEMENT (1) Reimbursement under the medicaid home and community services program is only available for services specified in the recipient's individual plan of care.

(2) Reimbursement for services is at those rates that are available under the terms of the contract that the department enters into with providers of services.

In the fall of 2000, CMS regional office reviewers noted that rates paid for services were not consistent across providers for the similar services. In response to CMS requests for justification of the various rates paid to providers for similar services, DDP elected to establish a new rate and reimbursement methodology. A contractor was hired to assist the State with this process. Currently, waiver recipients in DDP Region 2 are being served in accordance with the methodologies developed under the project. Policies and rules will be developed as the efforts of providers, Davis/Deshaies rates contractor staff, state staff and others refine the definitions and process on an ongoing basis.

Pilot Project Rate Description as of 1/06

The Montana Developmental Disabilities Program is converting its provider reimbursement approach from a negotiated rate system to a standardized fee-for-service system for its Medicaid Home and Community-Based Services (HCBS) waiver program. This conversion has been initiated in response to direction from the Montana state legislature and guidance from the federal Centers for Medicare and Medicaid. There are three major components to the DDP rate initiative:

1. Direct Care Staff Time as the Billable Unit: With the exception of adaptive equipment / environmental modifications and transportation, all provider reimbursement is based upon the amount of direct care staff time delivered to the consumer by the provider. In order to meet the conditions for payment, the consumer must be Medicaid eligible, enrolled, in attendance, and receive a HCBS service; and the direct care staff must be actively employed and providing the specified service as outlined under the unit definition and plan of care.
    - *Direct Care Staff Definition*: Direct care staff are those individuals whose primary responsibility is the day to day support of people with disabilities, training and instruction, and assistance with and management of activities of daily living. Direct care workers can be either employees of an agency, or may

be self-employed, so long as 85% of their work activities include daily supports to people with disabilities.

- *Billable Unit*: The term "billable unit" is used to describe the amount of service provided. The term "Hours" refers to a Direct Care Staff Hour. For services using this billable unit, agencies are reimbursed for each direct care staff hour provided. The term "Month" refers to a single month billing unit. For services using this billable unit, agencies are reimbursed a fixed monthly amount for all direct care hours provided to those people enrolled in their service for an entire month. Monthly rates are used when individual support needs can widely vary on a daily basis.

2. Standardized Cost Centers: All provider reimbursement rates consist of four cost centers. These cost centers are:

   ---*Direct Care Staff Compensation*

   ---*Employee-Related Expenses*

   ---*Program Supervision and Indirect Expenses*

   ---*General & Administrative Expenses*

   In addition to the standardized cost centers, geographical factors are applied for residential habilitation and day habilitation services; economy-of-scale and holiday factors are applied to residential habilitation. These factors are as follow:

   - *Geographical factor*: Geographical cost adjustment factors consider the cost of living, employment compensation, cost of housing, and labor market trends.

   - *Economy-of-Scale factor*: Economy-of-scale factors are used to adjust provider reimbursement for general & administrative (G&A) and program-related (PR) costs for agencies of different sizes.

   - *Holiday Coverage factor*: Each residential provider may identify up to ten (10) holidays per fiscal year; direct care staff hours provided on those days will be compensated at 1.5 times normal salary which providers must pass on to direct care staff.

Pilot Project History

HB2 of the 2005 Legislative Session supported the gradual implementation of published rates as outlined:

"Funding for the Disability Services Division includes funding that supports community services for developmentally disabled individuals and the implementation of a statewide published rate schedule for reimbursement of these services. Funding for these services

was appropriated by the legislature in a manner that supports a phased-in implementation of the published rate schedule, with one-quarter of the reimbursement for services provided to consumers transitioning to the published rate schedule each year. The department may adjust the timeframe for implementation of the published rate schedule if necessary to maintain federal Medicaid funding, avoid federal penalties, or achieve compliance with federal requirements. In the event that the timeframe for implementation of the published rate schedule is modified, the department shall notify members of the 2005 legislative joint appropriations subcommittee on health and human services prior to taking action to change the implementation schedule."

On January 1, 2005, DDP initiated Phase I of the rates pilot program that lasted through June 30, 2005. Due to the findings during this pilot, several adjustments were made to the rates and assessment tool to better accommodate the needs of providers and consumers.

Starting July 1, 2005, a Phase II pilot was initiated, which involves all adult providers in Region II (consisting of approximately 320 individuals in services). Based on legislative comments in HB2, the prior pilot findings, and updated provider information, the rates were adjusted to accommodate budget neutrality and are currently being tested and validated.

Coinciding with provider rates is the development of a resource allocation tool, otherwise known as the MONA. The MONA is a tool to allocate funding to individuals in services. This tool was also updated from the original pilot, and is further being tested during the current pilot in Region II.

The Phase II pilot is expected to end around June 2006. After the end of the current pilot, we expect the rates and assessment tool to be finalized and published. After finalization, the 'pilot' providers and individuals will immediately operate under the published rates. We developed an implementation plan for rate structure as designated by HB2. Starting July 2006, (FY2007) about 900 more individuals will be implemented into the published rate system from Regions I and III. July 2007, Region IV is planned to transition, and lastly, Region V in July 2008.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Flow of Billings

All DDP contractor billings flow directly from the contractor to the Department, and are entered into AWACS. This also applies to billings for service recipients in the rates pilot project in DDP Region 2.

Individuals must be Medicaid eligible and enrolled as Waiver Other (WO) on the WACI screen of TEAMS, the electronic link to the MMIS. TEAMS maintains electronic public benefits information, Medicaid enrollment and DD Waiver enrollment status. The DPHHS-DD/MA-55 Form is used by DDP field staff and the county Office of Public Assistance (OPA) Eligibility Technician to open the individual as Waiver Other (WO) on the WACI screen. The WACI screen is a dedicated screen in the TEAMS system maintaining the date(s) of enrollment and dis-

enrollment in Montana's waivers.

The start date on the MA 55 Form corresponds to the date of enrollment in the DD Waiver. Pre-printed invoices are issued to service providers by the DDP after the initial Individual Service Record (ISR) form is sent from the Provider to the DDP Regional Office. These invoices are completed on a monthly basis by providers, and then forwarded to the Regional Offices, where they are verified for accuracy and entered into the Agency Wide Accounting and Client System (AWACS). The AWACS invoicing system is tied to the public benefits information database via a link serving to notify the worker of individuals either not currently enrolled in the waiver and/or currently eligible for Medicaid.

Invoices are then forwarded to the DDP central office, approved for payment and the electronic information is sent to fiscal for payment via the statewide accounting and payments system (SABHRS). Hard copies of provider invoices are maintained at the DDP central and regional offices. Individual paid claims histories are maintained in the AWACS database indefinitely.

Linkage to ensure that individuals are not eligible to receive duplicated educational services under IDEA or duplicated services available from Vocational Rehabilitation (VR) is the responsibility of the assigned developmental disabilities case manager. The vast majority of individuals in this waiver have aged out of eligibility for school services. Given that the Waiver is payer of last resort and that funds are limited, planning team members have demonstrated due diligence in exploring all potential funding sources for needed services prior to committing waiver cost plan dollars.

c. Certifying Public Expenditures *(select one)*:

○		**Yes**. Public agencies directly expend funds for part or all of the cost of waiver services and certify their public expenditures (CPE) in lieu of billing that amount to Medicaid (*check each that applies*):
	☐	**Certified Public Expenditures (CPE) of State Public Agencies**. Specify: (a) the public agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-a.*)
	☐	**Certified Public Expenditures (CPE) of Non-State Public Agencies**. Specify: (a) the non-State public agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-b.*)
*		**No**. Public agencies do not certify expenditures for waiver services.

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for

payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

Payments are made to reimburse providers for services to persons enrolled and eligible for Medicaid at the time services were rendered. This is accomplished by the electronic link between AWACS and TEAMS. See Section C, above. If a person is not Medicaid eligible at the time the payment is approved by the DDP regional office administrative assistant, the name of the ineligible recipient is highlighted. Payments are normally reviewed and approved monthly.

The AWACS service option codes are loaded onto prepaid invoices based on the most recent Individual Service Record (ISR) form loaded into AWACS. These ISRs reflect service categories, and not necessarily specific supports within those categories. At the time that services are approved for payment, there is no third party review of the accuracy or validity of the provider's claim for reimbursement, but the recipient is verified in terms of being enrolled in the waiver, and currently eligible for Medicaid. Failure to deliver services specified in the plan of care may not be caught during the monthly billing process, but audit exceptions and QA discoveries can and have resulted in provider back payments.

In the rates system, the SURS process conducted by the Quality Assurance Division will help ensure the financial integrity of provider billing practices.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §74.53.

APPENDIX I-3: Payment

a. Method of payments — MMIS *(select one)*:

○	Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).
○	Payments for some, but not all, waiver services are made through an approved MMIS. Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64.
*	Payments for waiver services are not made through an approved MMIS. Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:
	The response to a, b, and c, above are explained in section I-2 b. (d) The basis for the draw of federal funds and the claiming of expenditures on the CMS-64 follows: When the expenditures identified in I-2.b. post to the Statewide Accounting Budgeting Human Resource System (SABHRS), federal funds are drawn down from the Smartlink system, via the Internet. Medicaid is a Cash Management Improvement Act (CMIA) grant; therefore, electronic fund transfers are drawn for immediately, and warrants are drawn on a six day clearance pattern. These expenditures are claimed on the appropriate waiver form on the CMS-64, which is then reconciled quarterly to the SABHRS system.
○	Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS. Describe how payments are made to the managed care entity or entities:

b. Direct payment. Payments for waiver services are made utilizing one or more of the following arrangements (*check each that applies*):

*	The Medicaid agency makes payments directly to providers of waiver services.
☐	The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.
☐	The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent. Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐	Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity. Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

*	**No**. The State does not make supplemental or enhanced payments for waiver services.
○	**Yes**. The State makes supplemental or enhanced payments for waiver services. Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made and (b) the types of providers to which such payments are made. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

d. Payments to Public Providers. *Specify whether public providers receive payment for the provision of waiver services.*

*	**Yes.** Public providers receive payment for waiver services. Specify the types of public providers that receive payment for waiver services and the services that the public providers furnish. *Complete item I-3-e.*
	The only public providers receiving payment from the DDP for waiver services are the public transportation providers.
○	**No**. Public providers do not receive payment for waiver services. *Do not complete Item I-3-e.*

e. **Amount of Payment to Public Providers**. Specify whether any public provider receives payments (including regular and any supplemental payments) that in the aggregate *exceed* its reasonable costs of providing waiver services and, if so, how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one*:

○	The amount paid to public providers is the same as the amount paid to private providers of the same service.
*	The amount paid to public providers differs from the amount paid to private providers of the same service, in the sense that transportation rates are not standardized at this time. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services. Standardized transportation rates are being developed in the rates methodology project at this time.

○	The amount paid to public providers differs from the amount paid to private providers of the same service. When a public provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report. Describe the recoupment process:

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

*	Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
○	Providers do not receive and retain 100 percent of the amount claimed to CMS for waiver services. Provide a full description of the billing, claims, or payment processes that result in less than 100% reimbursement of providers. Include: (a) the methodology for reduced or returned payments; (b) a complete listing of types of providers, the amount or percentage of payments that are reduced or returned; and, (c) the disposition and use of the funds retained or returned to the State (i.e., general fund, medical services account, etc.):
○	Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment. Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

○	**Yes**. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e). Specify the governmental agency (or agencies) to which reassignment may be made.
*	**No**. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

ii. Organized Health Care Delivery System. *Select one:*

*	**Yes**. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10. Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:
	(a) Entities are designated as OHCDS in the provider contract. Providers are designated as OHCDS in cases where the provider with the DD Contract subcontracts with other entities (persons or agencies) for the provision of services not provided by staff employed by the agency contracting with the DDP. Any person or agency providing services under a subcontract with an agency with a DDP contract must meet the DDP qualified provider standards for the provision of the service. It is the responsibility of the agency with the DDP contract to ensure the QP standards for the subcontracted service are met and documentation is maintained by the agency with the OHCDS designation to support this requirement. (b) Providers of waiver services may choose to contract directly with the DDP. The potential service provider would request a provider enrollment package from the DDP. After the required enrollment documentation has been reviewed and approved by the DDP Regional Manager and subject to a successful on onsite review of the physical site (if applicable) by the DDP, the applicant would achieve qualified provider status. The provider would then be enrolled as a Montana Medicaid Provider, although payment would flow through AWACS and not through the MMIS. (c) Service recipients are free to request the services of any qualified provider, as outlined in previous sections. Case managers are responsible for providing information to recipients and families regarding available service providers as part of the planning and pre-planning meeting process. Providers currently subcontract with various providers of professional and therapy services, in response to the expressed desires of the recipient and/or family. (d) All expenses associated with subcontractor payments are reported on the monthly invoices. These expenses may be discreet or bundled depending on the AWACS service option code assigned to the service category. Providers must break out, or "unbundle" AWACS service categories, as needed, to report the delivery of all waiver services by waiver service category in the provider Annual Expenditure Reports (AERs). This information is a critical piece of the paid claims history and audit trail, and is subject to review by independent, state and federal auditors.
○	**No**. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

○	The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may *voluntarily* elect to receive *waiver* and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.
○	This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain *waiver* and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.
*	The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

APPENDIX I-4: Non-Federal Matching Funds

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Check each that applies:*

	Appropriation of State Tax Revenues to the State Medicaid agency
☐	**Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.** If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by public agencies as CPEs, as indicated in Item I-2-c:
☐	**Other State Level Source(s) of Funds.** Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by public agencies as CPEs, as indicated in Item I-2- c:

b. Local or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Check each that applies:*

*	**Appropriation of Local Revenues.** Specify: (a) the local entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by public agencies as CPEs, as specified in Item I-2- c:

	In accordance with MCA 53-20-208, counties may access local tax levies for the purpose of supporting local services to persons with developmental disabilities. These funds are not matched with Medicaid. **53-20-208. Contributions of counties and municipalities.** (1) The boards of county commissioners of the several counties and the governing bodies of municipalities of this state may contribute to any developmental disabilities facility approved by the department, without regard to whether the facility is within or outside of their respective jurisdictions. Subject to 15-10-420, the boards of county commissioners of the counties may levy a tax on the taxable value of all taxable property within the county. The tax is in addition to all other county tax levies. All proceeds of the tax, if levied, must be used for the sole purpose of support of developmental disabilities services. (2) For the purpose of carrying out the provisions of this section, boards of county commissioners and governing bodies of municipalities may appropriate out of the general fund of their respective counties or municipalities. **History:** En. 80-2619 by Sec. 9, Ch. 325, L. 1974; Sec. 80-2619, R.C.M. 1947; amd. and redes. 71-2408 by Sec. 7, Ch. 239, L. 1975; R.C.M. 1947, 71-2408; amd. Sec. 131, Ch. 584, L. 1999; amd. Sec. 159, Ch. 574, L. 2001.
☐	**Other non-State Level Source(s) of Funds.** Specify: (a) the source of funds; (b) the entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by public agencies as CPEs, as specified in Item I-2- c:
☐	**Not Applicable**. There are no non-State level sources of funds for the non-federal share.

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources. *Check each that applies.*

☐	Provider taxes or fees
☐	Provider donations
☐	Federal funds (other than FFP)
	For each source of funds indicated above, describe the source of the funds in detail:
*	None of the foregoing sources of funds contribute to the non-federal share of computable waiver costs.

APPENDIX I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

○	No services under this waiver are furnished in residential settings other than the private residence of the individual. (*Do not complete Item I-5-b*).
*	As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual. (*Complete Item I-5-b*)

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

The cost of room and board is not reimbursable as a waiver expense, in accordance with the waiver service definitions. The amount charged to a recipient for room and board in a group home setting may leave the individual with insufficient personal funds. State General Fund supplemental payments enable a provider to cover costs associated with room and board expenses above and beyond a recipient's ability to pay with personal benefits income. In turn, the provider is responsible for ensuring recipients have personal needs money.

Currently, providers are reimbursed for the provision of waiver services under the terms of the provider contract for group home or supported living recipients based on service option codes and the number of recipients to be served. The providers are accountable for the expenditures of waiver funds as outlined in the associated rules, codes, contract and waiver language. Auditing requirements assist in ensuring that funds expended are in accordance with generally accepted accounting principles.

APPENDIX I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.
Select one:

○	**Yes**. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services. *The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:*
*	**No.** The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

APPENDIX I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services as provided in 42 CFR §447.50. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

*	**No**. The State does not impose a co-payment or similar charge upon participants for waiver services. (*Do not complete the remaining items; proceed to Item I-7-b*).
○	**Yes**. The State imposes a co-payment or similar charge upon participants for one or more waiver services. (*Complete the remaining items*)

i. Co-Pay Arrangement Specify the types of co-pay arrangements that are imposed on waiver participants *(check each that applies)*:

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*	
☐	Nominal deductible
☐	Coinsurance
☐	Co-Payment
☐	Other charge *(specify)*:

ii Participants Subject to Co-pay Charges for Waiver Services. Specify the groups of waiver participants who are subject to charges for the waiver services specified in Item I-7-a-iii and the groups for whom such charges are excluded. The groups of participants who are excluded must comply with 42 CFR §447.53.

iii. Amount of Co-Pay Charges for Waiver Services. In the following table, list the waiver services for which a charge is made, the amount of the charge, and the basis for determining the charge. The amount of the charge must comply with the maximum amounts set forth in 42 CFR §447.54.

Waiver Service	Amount of Charge	Basis of the Charge

iv. Cumulative Maximum Charges. Indicate whether there is a cumulative maximum amount for all co-payment charges to a waiver participant *(select one)*:

○	There is no cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.
○	There is a cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant. Specify the cumulative maximum and the time period to which the maximum applies:

v. Assurance. In accordance with 42 CFR §447.53(e), the State assures that no provider may deny waiver services to an individual who is eligible for the services on account of the individual's inability to pay a cost-sharing charge for a waiver service.

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants as provided in 42 CFR §447.50. *Select one:*

*	**No**. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.
○	**Yes**. The State imposes a premium, enrollment fee or similar cost-sharing arrangement. Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income as set forth in 42 CFR §447.52; (c) the groups of participants subject to cost-sharing and the groups who are excluded (groups of participants who are excluded must comply with 42 CFR §447.53); and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64: